

Principles for an Effective HIV Prevention, Care & Treatment Response for Most At-Risk Populations in Kenya

Liverpool VCT, Care & Treatment with Constella Futures recently supported the National AIDS Control Council to undertake two consultative meetings with sex workers, men who have sex with men and injecting drug users in Nairobi and Mombasa in order to inform the national Joint AIDS Programme Review – an annual process that measures and prioritizes national HIV response.

From these meetings, involving both 'beneficiaries' (i.e. SWs, MSM and IDUs themselves) and organizations providing services to these groups, ten key cross-cutting priorities for an effective HIV response for these most at-risk populations emerged.

Summary

There is growing recognition globally that HIV-related morbidity and mortality is significantly higher among vulnerable groups (also called 'most at-risk populations') than the general population. Further to this, vulnerable groups may often act as unwitting drivers of the HIV epidemic, particularly as HIV prevalence reduces within the general population.

As an annual process, the National AIDS Control Council coordinates the Joint AIDS Programme Review (JAPR) in order to provide a series of forums in which stakeholders outline the achievements made in the fight against the pandemic and determine gaps in HIV and AIDS interventions. Participants also identify major challenges and emerging issues, make recommendations for key actions, and identify lead agencies to implement the recommendations.

As such, as part of the JAPR process for 2008, and in line with the Kenya National AIDS Strategic Plan II, the NACC provided a forum for vulnerable groups, both beneficiaries and provider organizations, to participate and contribute to this process. This was achieved through two consultative workshops, in Mombasa and Nairobi, with representatives of sex workers, injecting drug users and men who have sex with men as well as organizations providing services to these groups.

The forums were lively and interesting and provided many insights into the needs of these groups, progress made, challenges to implementation and recommendations. During this process, 10 key priority areas emerged that are common to all three groups across the two locations. As such, the 10 key priorities for consideration at the national JAPR for 2008 are: criminalization of sex between men, intravenous drug use and legal issues surrounding sex work; registration of organizations of vulnerable groups; capacity

building of vulnerable groups; addressing stigma and intolerance towards the groups; creating and disseminating best practice documentation for vulnerable groups interventions; behavior change communication in terms of national communication strategies for each of the three groups and targeted and explicit IEC materials; addressing the disconnect between NACC and the CACCs at grass-roots levels; establishing operative technical working groups for the three areas; ensuring data collection is relevant to vulnerable groups; and building the capacity of health care providers to deliver quality services to vulnerable groups.

Cross-Cutting Priorities

During the preparatory consultation with vulnerable groups for the JAPR 2008, several themes emerged which were common to the three groups (MSM, SWs and IDUs) in both Mombasa and Nairobi. These cross-cutting themes are explored and contextualized below in order to provide greater insight into some of the main priorities and concerns that were raised in the consultative meetings and provide recommendations for a way forward.

I. Criminalization

The three groups (i.e. sex workers, men who have sex with men and injecting drug-users) have in common the criminalization of the activity which defines and characterizes them. Whilst sex work itself is not criminalized, female and male sex workers are often arrested and taken to court for 'loitering for the purpose of selling sex'. Sex between men is criminalized as 'carnal knowledge against the order of nature' and 'gross indecency', both carrying hefty prison sentences whilst injecting drug use is criminalized under the anti-drug laws enacted in 1994. Even when not charged with this offence, sex workers, MSM and IDUs will often be charged with 'public nuisance' or 'disorder'.

There are several significant effects of criminalization that have a direct bearing on HIV/AIDS prevention, care and treatment:

- Criminalization leads to service providers avoiding engaging with these groups for fear that by providing services to them they may be 'encouraging' the behaviour and thereby breaking the law
- The existence of these laws actively discourages sex workers, MSM and IDUs from accessing services for fear that they may be reported to the police
- Criminalization of these activities means that for sex workers and MSM their sexual behaviour often occurs clandestinely resulting in sexual encounters which are hurried; where there is little or no opportunity for condom negotiation; and where sex occurs in unsafe places

- For IDUs the result of criminalization is injecting drug use occurring hurriedly in unhygienic locations; without time or opportunity for needle and syringe sterilization; and high likelihood of needle-sharing
- Criminalization creates a barrier to the provision of condoms, lubricants, clean needles and syringes, needle-exchange programmes and targeted IEC materials for these groups as well as condom and lubricant distribution to sexually active males in prison
- The link between self-esteem and risk-taking behavior is well documented; criminalization results in psychological damage to the individual that encourages risky behaviour
- The law serves to encourage and promote stigma, discrimination, hostility and intolerance; laws that could be used to protect the rights of sex workers, MSM and IDUs from verbal and physical assault, police harassment and sexual violence, hate speech from religious leaders, bribery and blackmail are moot as a result of the groups standing in law
- Criminalization makes it extremely difficult for organizations to formally register themselves. This in turn makes it impossible for them to receive funds and inhibits their ability to meet and organize.

Recommendation:

Whilst the NACC may have limited scope to directly influence law making, it is recommended that the NACC undertake (or commission) a review of the effects of criminalization in the fight against HIV/AIDS as it pertains to vulnerable groups. This review, once submitted to the Attorney General's Office and the Kenya Law Reform Commission, could be utilized by civil society organizations to advocate for law reform in the interests of public health.

II. Stigma and Intolerance

All three groups highlighted the increase in hostility against them. This was particularly noted in Mombasa where it was reported that there has been a significant increase in hate speech by religious leaders targeted against all three groups. It was also noted that the Council of Imams and Preachers had, on a number of occasions, mobilized the community to interrupt HIV prevention activities and in one instance were successful in having an HIV outreach centre for MSM in Malindi closed. As mentioned above, the link between stigma, discrimination and intolerance and HIV risk is well documented.

Recommendation:

The NACC needs to mandate civil society to support groups and organizations of sex workers, MSM and IDUs to increase their capacity and build coalitions in order to undertake meaningful engagement with community and religious leaders. Further to this, the NACC must step up and make clear that stigma and discrimination of any kind (as recently witnessed at the Provincial JAPR in Coast) are intolerable and only serve to fuel the HIV epidemic. Funding provided to religious organizations could be granted on this basis.

III. Registration of Organisations

Criminalization and socio-cultural/religious stigma and hostility make it very difficult for groups and organizations of sex workers, MSM and IDUs to legally register their organizations. Non-registration results in barriers to receiving funding; barriers to conducting meetings legally; and permits police harassment.

Recommendation:

NACC is encouraged to support vulnerable groups to register by providing them with a letter of support for their legal registration, stating that NACC is aware of the nature of group and supports the HIV prevention activities it intend to undertake.

IV. Best Practice Documentation

It was once again highlighted during this process that there is a paucity of best practice documentation on HIV service provision for vulnerable groups. The result of this is a variety of groups and organizations utilizing funding for programmes that are neither evidence-based nor evidence-informed. Examples such as 'risk-reduction' models vis-à-vis 'alternative livelihood' and 'rescue' models were cited; were the latter have no evidence of efficacy.

Recommendation:

NACC may prioritize funding for the development and dissemination of best practice documentation for HIV programming for vulnerable groups. Potential partners suggested during this forum were ICRH, the Bar Hostesses Association, Liverpool VCT, Care & Treatment, Omari Trust and Tuonane.

V. Behaviour Change Communication – IEC Materials and Communication Strategies

Despite a wealth of evidence of the role of vulnerable groups in the HIV epidemic, 'mainstream' HIV IEC materials, such as those distributed by NACC and NASCOP, still make no mention of high-risk sex and mention needle-sharing only in the most cursory of ways. This is no longer acceptable in the face of the evidence of vulnerable groups' contribution to national HIV prevalence. Whilst a small number of organizations have developed and piloted IEC materials for MSM (see Liverpool VCT, Care & Treatment and KAVI) and IDUs (Tuonane/Omari Trust) but these have not recognized or mandated by NACC/NASCOP and their levels of distribution are low.

Whilst the creation of national BCC strategies for vulnerable groups has been on the JAPR agenda since 2006, only the communication strategy for youth has successfully been completed.

Recommendation:

NACC may prioritize funding for the production and dissemination of IEC materials targeting SWs, MSM and IDUs. NACC may also mandate these materials by providing their stamp of approval, literally, on these materials thereby sanctioning their distribution. Further to this, urgent attention must be made to the outstanding individual BCC communication strategies for MSM, SWs and IDUs with a serious commitment made by NACC to lead this process and prioritize funding.

VI. NACC – CACC Disconnect

During this process the leadership that NACC has demonstrated in raising awareness of the HIV needs of vulnerable groups was acknowledged and praised. However, it was highlighted that whilst NACC, at national level, has been eager to engage with and respond to SWs, MSM and IDUs, the response from provincial, district and in particular constituency level offices has often been poor. It was reported that applying and receiving funding at CACC level was not possible for SW, MSM and IDU organizations either as a result of the CACC officer's close relationship with the community (and thus fears of disclosure) or the officer's negative attitude.

Recommendation:

Three suggestions were posed by the groups; i) provide PACC, DACC and CACC employees with sensitization training on issues relating to SW, MSM and IDU; ii) ring-fence funding for vulnerable groups to ensure that CACCs grant a certain percentage of funding to vulnerable groups' organizations; iii) allow proposals from vulnerable groups at national level.

VII. Technical Working Groups

All three groups in both Mombasa and Nairobi recognized the importance of establishing functional technical working groups (TWGs) for MSM, SWs and IDUs at national level. Although this was captured in the JAPR report for 2007, only the TWG for IDUs is currently operational.

Recommendation:

Establish TWGs for MSM and SWs and capacity build TWG for IDUs (see table 'findings from Nairobi – IDUs – recommendations' above). It was stressed that the TWGs must be representational; being made up of both urban and rural beneficiaries and provider organizations.

VIII. Capacity Building

A commonality to the three groups in both locales was that the organizations of SWs, MSM and IDUs were often unregistered (see above), operated largely voluntarily and with few exceptions lacked technical capacity. Representatives of the SWs, MSM and IDUs made it clear that they are the most appropriately placed to be providing services and do not wish to become passive recipients of provider organizations. As such, the need to provide technical assistance and capacity building was highlighted to ensure that vulnerable groups' organizations are equipped to deliver quality and evidence-based services.

Recommendation:

NACC to prioritize funding to organizations providing TA and capacity building to groups and organizations of IDUs, MSM and SWs.

IX. Data Collection and Reporting

During this consultative process it was highlighted that data collection on vulnerable groups, specifically MSM, IDUs and SWs was not collected. For instance, the Kenya Demographic and Health Survey, whilst interrogating sexual debut and sexual practices, does not engage the issue of sex between men; anal sex (either heterosexual or homosexual); or transactional sex. The KDHS was described as

'heteronormative' and providing a misleading picture of sex and sexuality practices in Kenya. Further to this, the current VCT data form, whilst attempting to seek information on 'heterosexual' and 'homosexual' sex partners does so in such a way that either the counselor resists asking the question or the client refuses to answer and thus the data is useless. The current VCT data form does not collect data on high-risk sex and attempts to capture SW and IDU in only the most casual fashion. As such, without solid data collection, it has been impossible to establish meaningful indicators against which progress in HIV programming for vulnerable groups can be measured.

Recommendation:

NACC is encouraged to undertake a review of all relevant data collection tools and ensure that they are inclusive and vulnerable groups and in particular high-risk activities such as anal sex and injecting drug use. From this appropriate bench marks can be established as indicators of success of HIV programming for vulnerable groups.

X. Capacity of Health Care Providers

A concern common to all three groups at both consultative meetings was the capacity of health care providers (HCPs) to provide appropriate, non-judgemental and non-stigmatizing services to SWs, MSM and IDUs. Highlighted by research undertaken by Population Council and FHI, it was stressed that many SWs, MSM and IDUs choose not to access services and opt to self-medicate rather than risk embarrassment and hostility from those with the responsibility to care for them. Reports of negative interactions at VCT centers, STI clinics and HIV CCCs were common to SWs, MSM and IDUs in both Nairobi and Mombasa. It was emphasized that the training HCPs receive does not equip them to be sensitive or aware of the needs of these groups.

Recommendation:

NACC can support a national review of curricula used to train HCPs to ensure that sexuality education in relation to HIV is of primary import as well as being sensitively and appropriately delivered.

Consolidated Priorities

KNASP Area	Successes	Challenges	Emerging Issues	Priority Recommendation
MCG 1 – Prevention of New Infections				

1.1 <i>Counseling & Testing</i>	Anecdotal increase in numbers of MSM, SWs and IDUs accessing VCT services	VCT and other HCPs not equipped to meet needs to MSM, IDUs and SWs VCT data collection tool does not adequately capture MSM, IDUs and SWs	Many MSM, SWs and IDUs report negative experiences in VCT and other health services	Review of VCT and broader HCP training to incorporate issues relevant to MSM, SWs and IDUs Review of national CT data collection tools to capture MSM, SWs and IDUs (see also 4.1 and 4.4 below)
1.5 Behaviour Change Communication - strategies	MSM BCC Communication Strategy initiated but not completed	MSM TWG not operational (see also 4.5 below)		Initiate and complete BCC Communication Strategies for MSM, SWs and IDUs through consultative process
1.5 Behaviour Change Communication - materials	Small number of organizations producing limited number of targeted IEC materials	Absence of nationally available targeted IEC materials and lack of relevant content in mainstream IEC materials		Prioritize funding for the production and distribution of targeted IEC materials for MSM, IDUs and SWs and ensure NACC mandating of same

MCG 2 - Improvement of the Quality of Life of People Infected and Affected by HIV/AIDS

2.2 Care		Increasing stigma and hostility towards MSM, SWs and IDUs particularly from religious leaders	Increasing HIV stigma with MSM communities	Support capacity building of vulnerable groups organizations to engage religious and community leaders in a meaningful way Support HIV stigma-
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				<p>reduction for vulnerable groups through peer-led support groups</p> <p>Link funding to religious groups to 'no stigma' pledge</p>
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<p>2.3 Protection of Human Rights</p>		<p>Criminalization of sex work, IDU and legislation around SW creates multiple barriers to prevention, care & treatment services and increases stigma and discrimination</p>	<p>Vulnerable groups organizations unable to register or open bank accounts due to legal barriers</p> <p>(see also 3.5 below)</p>	<p>Commission review of effects of criminalization of vulnerable groups and barriers to HIV prevention, care & treatment</p>
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MCG 3 – Mitigation of Socio-Economic Impact of HIV/AIDS

<p>3.5 Community Empowerment</p>		<p>Organizations of MSM, SWs and IDUs unable to get legal registration</p> <p>Organizations of MSM, SWs and IDUs lack technical capacity</p>	<p>Without legal registration, organizations cannot open bank accounts or receive funding</p>	<p>NACC to issue letters of support to organizations making requests to register</p> <p>NACC to request relevant ministries to support registration of MSM, IDU and SW organizations</p> <p>Prioritize funding to organizations proving TA and capacity building to MSM, SW and IDU organizations</p>
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MCG 4 – KNASP Support Services

<p>4.1 M&E</p>		<p>Weaknesses in data collection pertaining to MSM, IDUs and SWs</p>	<p>KDHS, VCT and other data collection ignores MSM, IDUs and SWs or collects data inadequately resulting in absence of meaningful indicators for vulnerable groups</p>	<p>Undertake a review of all relevant data collection tools and ensure that they are inclusive and vulnerable groups and in particular high-risk</p>
<p>4.4 Institutional Capacity Building</p>	<p>Small increase in number of VCT counselors sensitized to needs of MSM, SWs and IDUs</p>	<p>Majority of VCT counselors and other HCPs not equipped to meet service needs of vulnerable populations</p> <p>There is a disconnect between NACC and CACCs in response to MSM, SWs and IDUs</p>	<p>Many MSM, SWs and IDUs report negative experiences in VCT and other health services</p> <p>PACC, DACC and CACC staff lack capacity to engage MSM, SWs and IDUs sensitively and appropriately</p>	<p>Review of VCT and broader HCP training to incorporate issues relevant to MSM, SWs and IDUs</p> <p>Provide sensitivity training to PACC, DACC and CACC staff and make vulnerable groups participation part of service performance contracts</p>
<p>4.5 Communication, Coordination and Networking</p>	<p>TWG for IDU in operation</p>	<p>TWGs for SWs and MSM non-operational</p>	<p>Representative TWGs for vulnerable groups of high importance</p>	<p>Establish and operationalize TWGs with immediate affect</p>

	Small number of innovative programmes for MSM, SWs and IDUs in operations	Absence of best practice documentation for MSM, SWs and IDUs HIV programming		Prioritize funding for best practice development, documentation and dissemination
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Conclusion

The ten key cross-cutting priorities and recommendations for an effective HIV prevention, care and treatment response for most at-risk populations in Kenya form a robust list of objectives for HIV programming in this area. The National AIDS Control Council and stakeholders in the fight against AIDS in Kenya are urged to prioritize these areas in the current JAPR 2008 process and the upcoming formulation of the Kenya National AIDS Strategic Plan III as well as at organizational level through effective and responsive programming.

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